STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150042	A. BUILDING _____ B. WING _____	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOSPITAL	520 S 7TH ST VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Complaint number: IN00097874 Substantiated; No deficiencies related to allegation cited. Date of survey: 1-10-12 Facility number: 005038 Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Good Samaritan Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.6-8, Surgical services, Hospital Licensure Rules. QA: claughlin 01/19/12	S 000		